UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

LUANN P. GOULD, Plaintiff, – against – LUCENT TECHNOLOGIES, INC., Defendant.	ORIGINAL FILED VIA ECF 05 CV 11118 (PBS) **AFFIDAVIT OF MARGARET BLUMER IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT**

STATE OF NEW JERSEY)
) ss.:
COUNTY OF MORRIS)

MARGARET BLUMER, being duly sworn, deposes and says:

1. I make this Affidavit in support of the Lucent Technology Inc.'s ("Lucent") motion for summary judgment.

2. I am currently employed by Lucent as an Authorized Benefit Delegate. As such, I have personal knowledge and information of the facts and circumstances set forth in this Affidavit.

3. From 1996 through 2003, Plaintiff Luann Gould ("Gould") requested and was granted at least 7 leaves of absence under the FMLA, for a combined total of 285.5 days off from work. Not one of these FMLA absences counted toward or triggered any action against Gould under Lucent's Absence Control Plan.

4. From May 5 through May 6, 2003, Gould missed two days of work. While Gould completed and provided Lucent with FMLA paperwork for these two absences, the

documentation was vague, merely indicating that Gould was absent due to a one-day illness of her daughter, which was neither chronic nor required additional treatment. [Exhibit A] As this documentation did not support a determination that Gould's daughter suffered from a "serious health condition" within the meaning of the FMLA, e.g. was ill for more than three consecutive days, on or around May 23, 2005, I asked Gould to submit additional information concerning her daughter's illness. At that time, Lucent had not yet denied Gould's request for FMLA leave.

5. To further assist Gould in qualifying her leave under the FMLA, Gould's supervisor, Pyong Deletis ("Deletis") personally contacted me, inquiring whether she could do anything to help Gould. I informed Deletis to "just make sure she provides all the documentation that is necessary."

6. While Gould provided Lucent with this additional FMLA paperwork, it too failed to establish that her daughter suffered from any serious medical condition. [Exhibit B]. As a result, I disqualified Gould's May 5-6 leave under the FMLA for failure to meet the criteria of a "serious health condition." [Exhibit C]

7. On or around July 11, 2003, Gould, for the third time, submitted additional medical certification concerning her daughter's two-day illness in May. [Exhibit D] This additional documentation, however, again fell far short of the FMLA's standard requiring a period of incapacity (i.e. inability to work, attend school ...) of more than three consecutive days. Id. The certification stated that, "Ms. Gould's daughter was being treated for chicken pox" and could not go two school for two days. Id. Because this certification failed to establish that Gould's daughter suffered from any condition lasting more than three consecutive days, by

letter dated July 14, 2003, I sustained my determination that Gould's leave failed to qualify under the FMLA. [Exhibit E]

8. On July 25, 2003, Gould attempted to qualify her one day leave on July 7, 2003 under the FMLA by providing to Lucent, for the first time, FMLA documentation. [Exhibit F] The documentation stated that "patient needed to miss work on Monday, July 7, 2003 to stay home with her daughter, who had bacterial conjunctivitis and was contagious" and "needed to be kept home for 24 hours." Id. It further stated that the daughter's condition was neither chronic nor required additional treatments. Id. By letter dated July 28, 2003, I informed Gould that her July 7 leave did not qualify under the FMLA, as Plaintiff's daughter did not suffer from a serious medical condition. [Exhibit G]

9. As a final attempt to resolve the status of the May and July, 2003 leaves, on September 19, 2003, Gould provided Lucent once again with additional documentation concerning the reasons for the absences, including a letter from Gould's daughter's school dated September 18, 2005. [Exhibit H] The letter from the school stated, among other things, that in connection with her chicken pox, "...Shelby was only absent for 2 days before she was cleared to return to school..." Id. In connection with the conjunctivitis, the letter stated that "Shelby missed one day of school when she contacted conjunctivitis last July." Id. After careful review of these most recent documents, on September 25, 2003, I denied Gould's request to qualify the leaves under the FMLA for the final time. [Exhibit I]

10. In or around January 2004, Plaintiff filed a claim with the United States Department of Labor ("DOL"), claiming a violation of the FMLA. On March 16, 2004, after a thorough investigation, including interviewing witnesses and reviewing the records concerning

Plaintiff's attendance, the DOL dismissed her FMLA claims, finding no violation of the law. Upon information and belief, Plaintiff never filed any complaint with the Attorney General's Office concerning her SNLA claims.

WHEREFORE, I respectfully request that the Court grant Defendant's summary judgment motion in its entirety.

Margaret Blumer

Sworn to before me this
18th day of August 2006.

DAHLIA MICHAEL
NOTARY PUBLIC OF NEW JERSEY
My Commission Expires Feb. 17, 2010

Notary Public

EXHIBIT A

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

LT-FMLA-1
(5/98)
page 1 of 2

Family and Medical Leave of Absence (FMLA) Notification Form

Employee's Name: Luann P. Gould		Job Title: Assembler	HRID No.: 7718725
Social Security No.: 002-52-9611	Net Credited Service Date: 10-16-79	Organization Code:	
Employee's Work Address (include city and state and zip code): 1600 OSGood St. N. Andover		Work Tel. No.: 1-603-382-3977	
Employee's Address During Leave of Absence: 19 Bittersweet Way Danville NH		Home/Reach Tel. No.:	

Family and Medical Leave of Absence Notification

I hereby request a Leave of Absence under the Family and Medical Leave Act of 1993 (FMLA) to begin on 5-5 *and to continue through* 5-7 *for the following reason. (Check appropriate box below. If request is for intermittent leave or leave on a reduced leave schedule, please indicate proposed schedule below.)*

- r The birth of my child*
- r Placement with me of a child for adoption or foster care*
- r Care for a family member** (☐ my spouse, ☐ my parent, ☑ my child - date of child's birth 7-22-97)
- r My own serious health condition**

* **Proof of relationship required**

** **Form FMLA - 2 must be completed and returned with this form**

Proposed intermittent leave or reduced leave schedule:

To Be Completed By Employee's Supervisor

(Supervisor: Please keep a photocopy of the signed FMLA-1 for your files. Return original form to the employee.)

☑ Employee has leave entitlement under the FMLA. Total FMLA leave taken during the current 12-month period: 42.6 DAYS

Brian Allen	SOAH Supervisor	978-960-3044	5/15/03
(Reviewed By) Supervisor's Signature	Job Title	Tel. No.	Date
BRIAN ALLEN	1600 OSGOOD ST N. ANDOVER MA 01845		
Type or Print Supervisor's Name	Supervisor's Complete Work Address	30-2-N27	

Review Of Conditions Of Leave Of Absence (See both sides of this form)

I have read and fully understand my rights and responsibilities under the FMLA specified on both sides of this form. I understand that if I do not return to the active payroll at or prior to the end of my leave, my employment will be terminated and the continuity of my service will be broken retroactive to the first day of my leave. I also understand that if I do not submit an FMLA-2 Form (FMLA Healthcare Provider's Report) as requested, I may not qualify for FMLA leave and the absence may be charged against my attendance record. Employees who fraudulently obtain FMLA leave are not protected by the Act.

Employee's Signature Luann Gould **Date** 5-17-03

Service Credit

Upon reinstatement from an FMLA leave (taken as consecutive calendar days or on an intermittent basis), an employee will receive Net Credited Service for the first 30 days of unpaid FMLA leave within a 12-month period. Employees granted multiple leaves of absence within a 12-month period will not be granted more than one 30-day period of service credit within a 12-month period. An employee who has an absence which qualifies under the provisions of the FMLA and who subsequently returns from such a leave will be credited with up to 501 hours, either in the year of absence or in the following year as necessary, to prevent a break in service for participation and vesting under the applicable pension plan. Any hours credited will be used only to avoid a break in service for participation and vesting under the applicable pension plan and will not be counted toward Vesting Service or eligibility to participate, nor will they be included in Net Credited Service.

To Be Completed by Health Services.

This FMLA is ☐ qualified ☒ not qualified, for the period from 5/5/03 to 5/7/03 inclusive, subject to the rights and conditions set forth on both sides of this form.

Reviewed by: Kathy Turner Date: 7/7/03

Authorized Benefit Delegate

Please also read "Your Rights and Responsibilities Under the Family and Medical Leave Act of 1993" on the reverse side of this form.

Benefit Office Copy

LT-FMLA-2
(5/98)

FMLA Healthcare Provider's Report
(Family and Medical Leave Act of 1993)

To (Healthcare Provider's Name): Greater Hampstead Family

I hereby authorize you to provide information to Lucent Technologies Inc. Health Services for purposes of clarifying the information provided in this FMLA Healthcare Provider's Report.

Luanna Gould — Patient's Signature (if minor, Guardian Signature)

5-7-03 — (Date)

1. Employee's Name: Luanna Gould Social Security Number 002-52-9611

2. Patient's name (if different from employee): Shelby Gould

Relationship to employee: daughter If child, date of birth: 7-22-97

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(I)___ (II)___ (III)___ (IV)___ (V)___ (VI)___, or None of the above___

4. Describe the medical facts which support your response to Item 3 above, including a brief statement as to how the medical facts meet the criteria of one of these categories:
Luanna was absent due to illness of her daughter.

5 a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):
began 5/7/03 and was expected to return to normal activities on 5/7/03.

5 b. Will it be necessary for the employee to work only intermittently or to work on less than a full schedule as a result of the condition (including for treatment described in Item 6 below)? YES:___ NO: (circled)

If yes, give the probable duration: ___

5 c. If the condition is a chronic condition (condition #IV) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:
Not Chronic.

6 a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: None

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any: N/A

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2]"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Health Service's Copy

EXHIBIT B

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

LUANN Gould
8-9-59

LT-FMLA-2
(5/98)

6 b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments: No

6 c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, therapy requiring special equipment): None

7 a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?
YES:___ NO: X

7 b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee should supply you with information about the essential job functions)?
YES:___ NO: X

If yes, please list the essential functions the employee is unable to perform: _____

7 c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? YES:___ NO: X

If yes, please list the date(s) of treatment for which the employee will be required to be absent from work.

8 a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? YES:___ NO: X

8 b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? YES:___ NO: X

8 c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: Patient to work without 1 day

(Signature of Healthcare Provider) BENJAMIN HOLOBOWICZ, PA-C (Name of Practice)
GR. HAMPSTEAD FAMILY MED.
207 STAGE RD
(Address) PO BOX 458 (Telephone Number)
HAMPSTEAD, NH 03841
603-329-5222

To be completed by the employee needing FMLA leave to care for a family member:

9. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Luann Gould (Employee Signature) 7-2-03 (Date)

THIS FORM MUST BE RETURNED TO THE APPROPRIATE HEALTH SERVICES CLINIC LOCATION. (See cover sheet for addresses.)
DO NOT RETURN THIS FORM TO YOUR SUPERVISOR

Health Service's Copy

EXHIBIT C

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

Lucent Technologies
Bell Labs Innovations

67 Whippany Road, W
Room Room 4A - 127
Whippany, NJ 07981 USA

Phone 973 386 2000
Fax 973 386 4184

July 7, 2003

Luann Gould
14 Billy's Way
Danville, NH 03819-

Re: Family and Medical Leave Act (FMLA)

Dear Luann Gould,

This letter is to inform you of the qualification status for your leave under the Family and Medical Leave Act (FMLA) from 05/05/2003 through 05/07/2003. This leave is "*Not Qualified*", since the absence does not meet the criteria of a "serious health condition" as described below:

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

- **Hospital Care**: Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

- **Absence Plus Treatment**: A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves: (1) Treatment two or more times by a healthcare provider, by a nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services(e.g., physical therapist) under orders of, or on referral by, a healthcare provider; or (2) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the healthcare provider.

- **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.

- **Chronic Conditions Requiring Treatments**: A chronic condition which: (1) Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a healthcare provider; (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

Serious Health Condition (cont'd.)

- **Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

- **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments, including any period of recovery therefrom) by a healthcare provider or by a provider of health care services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Please call me if you have any questions regarding this matter.

Peggy Blumer

Peggy Blumer
Benefit Representative

(973) 386-5012
Telephone Number

(973) 884-3726
Fax Number

Copy to
Deletis, Pyong

EXHIBIT D

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

Greater Hampstead Family Medicine, PC
207 Stage Rd
PO Box 458
Hampstead, NH 03841
603-329-5222

Date: 07/09/2003

To Whom It May Concern:

LUANN GOULD has been under my professional care for the treatment of her daughter from 5-5-03 to 5-6-03 and may return to work on 5-7-03 with the following restrictions:

None. Ms Gould's daughter was being treated for chicken pox and therefore could not go to daycare because of contagiousness

If you have any questions regarding this patient please feel free to call me.

Sincerely,

Thomas J. Cammilleri, D.O.
Benjamin Holobowicz, PA-C
Nicole May, PA-C
Carol Renouf, ARNP

Start — May 5 First
Duration of illness?
Complications? ϕ
Medications? ϕ
Mon 5/5
Tues 5/6
Wed. 5/7
" — RN
11/14/03 Lisa C. [illegible]

EXHIBIT E

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

Lucent Technologies
Bell Labs Innovations

67 Whippany Road, W
Room Room 4A - 127
Whippany, NJ 07981 USA

Phone 973 386 2000
Fax 973 386 4184

July 14, 2003

Luann Gould
14 Billy's Way
Danville, NH 03819

Dear Luann,

Please be advised that after careful review of the most recent information you submitted to me on Friday, July 11, 2003, the FMLA qualification for the period May 5 thru May 7, 2003, remains "Not Qualified."

The medical documentation I received from your provider does not satisfy the criteria of a "serious health condition" as defined by the Federal Guidelines governing the FMLA. This criteria was outlined in the letter I sent to you on July 7, 2003. Childhood illness does not qualify under the FMLA, unless there are complications.

Please call me if you have any questions concerning this matter.

Sincerely,

Peggy Blumer
Authorized Benefit Delegate
973-386-5012

Cc: Stephen Sickel
Brain Campbell
Pyong Deletis

EXHIBIT F

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

LT-FMLA-1
(5/98)
page 1 of 2

Family and Medical Leave of Absence (FMLA) Notification Form

Employee's Name	Job Title	HRID No.
Luann P. Gould	Level 1	7718725
Social Security No. 002-52-9611	**Net Credited Service Date** 10-16-79	**Organization Code**
Employee's Work Address (include city and state and zip code) 1600 OSGood St. N. Andover ma.	**Work Tel. No.** 1-978-960-3514	
Employee's Address During Leave of Absence 14 Billy's way Danville NH 03819	**Home/Reach Tel. No.** 1-603-382-3977	

Family and Medical Leave of Absence Notification

I hereby request a Leave of Absence under the Family and Medical Leave Act of 1993 (FMLA) to begin on 7-7-03 *and to continue through* 7-8-03 *for the following reason. (Check appropriate box below. If request is for intermittent leave or leave on a reduced leave schedule, please indicate proposed schedule below.)*

- ☐ The birth of my child*
- ☐ Placement with me of a child for adoption or foster care*
- ☐ Care for a family member** (☐ my spouse, ☐ my parent, ☑ my child - date of child's birth 7-22-98
- ☐ My own serious health condition**

* Proof of relationship required
** Form FMLA - 2 must be completed and returned with this form

Proposed intermittent leave or reduced leave schedule: I need to apply for intermittent leave for illness that may occur in future, to avoid any complications that may arise

To Be Completed By Employee's Supervisor

(Supervisor: Please keep a photocopy of the signed FMLA-1 for your files. Return original form to the employee.)

2 DAYS PENDING

Employee has leave entitlement under the FMLA. Total FMLA leave taken during the current 12-month period: 38.2 DAYS

(Reviewed By) Supervisor's Signature: Brian Allen FOR PYONG DELETIS	Job Title: HAY SUPERVISOR	Tel. No.: 978-960-3514	Date:
Type or Print Supervisor's Name: BRIAN ALLEN	Supervisor's Complete Work Address: 1600 OSGOOD ST N. ANDOVER, MA 01843 30-2-X9		

Review Of Conditions Of Leave Of Absence (See both sides of this form)

I have read and fully understand my rights and responsibilities under the FMLA specified on both sides of this form. I understand that if I do not return to the active payroll at or prior to the end of my leave, my employment will be terminated and the continuity of my service will be broken retroactive to the first day of my leave. I also understand that if I do not submit an FMLA-2 Form (FMLA Healthcare Provider's Report) as requested, I may not qualify for FMLA leave and the absence may be charged against my attendance record. Employees who fraudulently obtain FMLA leave are not protected by the Act.

Employee's Signature: Luann Gould Date: 7-10-03

Service Credit

Upon reinstatement from an FMLA leave (taken as consecutive calendar days or on an intermittent basis), an employee will receive Net Credited Service for the first 30 days of unpaid FMLA leave within a 12-month period. Employees granted multiple leaves of absence within a 12-month period will not be granted more than one 30-day period of service credit within a 12-month period. An employee who has an absence which qualifies under the provisions of the FMLA and who subsequently returns from such a leave will be credited with up to 501 hours, either in the year of absence or in the following year as necessary, to prevent a break in service for participation and vesting under the applicable pension plan. Any hours credited will be used only to avoid a break in service for participation and vesting under the applicable pension plan and will not be counted toward Vesting Service or eligibility to participate, nor will they be included in Net Credited Service.

To Be Completed by Health Services.

This FMLA is ☐ qualified ☒ not qualified, for the period from 7/1/03 to 7/1/03 inclusive, subject to the rights and conditions set forth on both sides of this form.

Reviewed by: Kathy Blunier Date: 7/25/03
Authorized Benefit Delegate

Please also read "Your Rights and Responsibilities Under the Family and Medical Leave Act of 1993" on the reverse side of this form.

LT FMLA-2
(5/98)
Page 1 of 4

FMLA Healthcare Provider's Report
(Family and Medical Leave Act of 1993)

To (Healthcare Provider's Name): Nicole May PA-C

I hereby authorize you to provide information to Lucent Technologies Inc. Health Services for purposes of clarifying the information provided in this FMLA Healthcare Provider's Report

Luann Gould — 7-7-03
Patient's Signature (if minor, Guardian Signature) (Date)

1. Employee's Name: Luann Gould Social Security Number 002-52-9611

2. Patient's name (if different from employee): Sherry Gould

Relationship to employee: Daughter If child, date of birth: 7-22-97

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(I)___ (II)X (III)___ (IV)___ (V)___ (VI)___, or None of the above___

4. Describe the medical facts which support your response to Item 3 above, including a brief statement as to how the medical facts meet the criteria of one of these categories
Patient needed to miss work on Monday 7/7/03 to stay home with the daughter who had bacterial conjunctivitis + otitis diagnosis

5 a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different): Patient needed to stay home for 24 hours so Luann Gould needed to miss work on 7/7/03 only

5 b. Will it be necessary for the employee to work only intermittently or to work on less than a full schedule as a result of the condition (including for treatment described in Item 6 below)? YES:___ NO: X

If yes, give the probable duration: ___

5 c. If the condition is a chronic condition (condition #IV) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]: N/A

6 a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: N/A

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any: N/A

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2]"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

6 b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments: N/A

6 c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, therapy requiring special equipment):

Erythromycin Ointment - qid x approx. 5 days

7 a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?
YES:___ NO:___ N/A

7 b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee should supply you with information about the essential job functions)?
YES:___ NO:___ N/A

If yes, please list the essential functions the employee is unable to perform:

7 c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? YES:___ NO:___

If yes, please list the date(s) of treatment for which the employee will be required to be absent from work.

N/A

8 a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? YES: ✓ NO:

Safety as patient is a minor

8 b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? YES:___ NO:___

8 c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

7/7/03 only

Heidi Bate
(Signature of Healthcare Provider)

Family Practice
(Type of Practice)

207 Stage Road Hampstead NH
(Address)

603 329-5223
(Telephone Number)

To be completed by the employee needing FMLA leave to care for a family member:

9. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Deborah Gould
(Employee Signature)

7-16-03
(Date)

THIS FORM MUST BE RETURNED TO THE APPROPRIATE HEALTH SERVICES CLINIC LOCATION. (See cover sheet for addresses.)
DO NOT RETURN THIS FORM TO YOUR SUPERVISOR

Health Service's Copy

EXHIBIT G

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

Lucent Technologies
Bell Labs Innovations

67 Whippany Road, W
Room Room 4A - 127
Whippany, NJ 07981 USA

Phone 973 386 2000
Fax 973 386 4184

July 28, 2003

Luann Gould
14 Billy's Way
Danville, NH 03819-

Re: Family and Medical Leave Act (FMLA)

Dear Luann Gould,

This letter is to inform you of the qualification status for your leave under the Family and Medical Leave Act (FMLA) from 07/07/2003 through 07/07/2003. This leave is "*Not Qualified*", since the absence does not meet the criteria of a "serious health condition" as described below:

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

- **Hospital Care**: Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

- **Absence Plus Treatment**: A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves: (1) Treatment two or more times by a healthcare provider, by a nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services(e.g., physical therapist) under orders of, or on referral by, a healthcare provider; or (2) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the healthcare provider.

- **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.

- **Chronic Conditions Requiring Treatments**: A chronic condition which: (1) Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a healthcare provider; (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

Serious Health Condition (cont'd.)

- **Permanent/Long-term Conditions Requiring Supervision**: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

- **Multiple Treatments (Non-Chronic Conditions)**: Any period of absence to receive multiple treatments, including any period of recovery therefrom) by a healthcare provider or by a provider of health care services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Please call me if you have any questions regarding this matter.

Peggy Blumer

Peggy Blumer
Benefit Representative

(973) 386-5012
Telephone Number

(973) 884-3726
Fax Number

Copy to
Deletis, Pyong

EXHIBIT H

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

LT-FMLA-2
(5/03)
Page 1 of 4

FMLA Healthcare Provider's Report
(Family and Medical Leave Act of 1993)

To (Healthcare Provider's Name): _____

I hereby authorize you to provide information to Lucent Technologies Inc. Health Services for purposes of clarifying the information provided in this FMLA Healthcare Provider's Report.

Luana Gould — 9-19-03
Patient's Signature (if minor, Guardian Signature) (Date)

1. Employee's Name: Luana Gould Social Security Number 002-52-9618

2. Patient's name (if different from employee): Shelby Gould

Relationship to employee: Daughter If child, date of birth: 7-22-97

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(I)___ (II)X (III)___ (IV)___ (V)___ (VI)___ or None of the above___

4. Describe the medical facts which support your response to Item 3 above, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Contagious/quarantined with possible chicken pox.

5 a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different): Lesions first noticed on 5/3/03 by patients mother, is expected to return to normal activities on 5/7/03

5 b. Will it be necessary for the employee to work only intermittently or to work on less than a full schedule as a result of the condition (including for treatment described in Item 6 below)? YES:___ NO:X

If yes, give the probable duration: _____

5 c. If the condition is a chronic condition (condition #IV) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]: N/A

6 a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: N/A

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any: _____

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

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(5/03)

6 b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments: N/A

6 c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, therapy requiring special equipment): Benadryl / Aveeno Bath ~3 days
Quarantine

7 a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? YES:___ NO:___ N/A

7 b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee should supply you with information about the essential job functions)? YES:___ NO:___ N/A

If yes, please list the essential functions the employee is unable to perform: _____

7 c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? YES:___ NO:___ N/

If yes, please list the date(s) of treatment for which the employee will be required to be absent from work.

8 a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? YES:X NO:___
Safety of a minor

8 b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? YES:✓ NO:___
In addition to 8a.

8 c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: N/A

Nicole May PAC
(Signature of Healthcare Provider)

NICOLE MAY, PA-C
QR, HAMPSTEAD MED.
207 STAGE RD
PO BOX 458
HAMPSTEAD, NH 03841
603-329-5222
(Type of Practice)

(Address)

(Telephone Number)

To be completed by the employee needing FMLA leave to care for a family member:

9. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee Signature)

(Date)

THIS FORM MUST BE RETURNED TO THE APPROPRIATE HEALTH SERVICES CLINIC LOCATION. (See cover sheet for addresses.)
DO NOT RETURN THIS FORM TO YOUR SUPERVISOR

09/24/03 09:09 AT&T MVW LABOR RELATIONS → LUCENT TECHNOLOG NO.818 P004/006
9786884511
FROM :CWA LOCAL 1365 FAX NO. :9786884511 Sep. 23 2003 02:40PM P4

THE HAMPSTEAD VILLAGE PRESCHOOL, INC.
NURSERY SCHOOL, KINDERGARTEN, AND DAY CARE

September 18, 2003

To Whom It May Concern:

I am writing this letter to confirm that on May 5 & 6, 2003 Shelby Gould was absent from school due to the Chicken Pox. She also was absent on July 7, 2003 due to Conjunctivitis.

According to the New Hampshire Division of Public Health Services and The Hampstead Village Preschool's Parent Handbook, children that have any contagious disease must be excluded from school or Day Care settings.

I have included a copy of the guidelines set forth by the NH Division of Public Health Services concerning theses two communicable and contagious childhood diseases. Although each child exhibits different degrees of chicken pox, it is normal for a child to be out of school for 5-7 days until they are no longer contagious. Shelby was only absent for 2 days, before she was cleared to return to school.

It is the policy the any child with conjunctivitis must be excluded from school/Daycare for at least 24 hrs after they begin medication. Antibiotics protect a child from being contagious only after 24 hrs form the first time they ingest the medication. Shelby missed one day of school when she contacted Conjunctivitis last July. Missing 1 day of school is the minimum amount of time required before returning.

If you have any further questions. Feel free to call me at the preschool.

Sincerely,

~K~

Kathy Richard
Owner/Director

185 Brown Hill Road. East Hampstead. New Hampshire 03826 • (603) 382-3696

EXHIBIT I

(to Affidavit of Margaret Blumer in Support of Defendant's Motion for Summary Judgment)

Lucent Technologies
Bell Labs Innovations

67 Whippany Road.
Room 4A - 159
Whippany. NJ 07981 USA

Phone 973 386 2000
Phone 973 386 4184

September 25, 2003

Luann Gould
14 Billy's Way
Danville, NH 03819

Dear Luann,

Please be advised that after careful review of the most recent information you have submitted, received 9/23/03, the FMLA qualification for the period May 5 thru May 7, 2003, remains "Not Qualified."

The medical documentation I received from your provider does not satisfy the criteria of a "serious health condition" as defined by the Federal Guidelines governing the FMLA. This criteria was outlined in the letter I sent to you on July 14, 2003. Childhood illness does not qualify under the FMLA, unless there are complications.

Please call me if you have any questions concerning this matter.

Sincerely,

Peggy Blumer
Authorized Benefit Delegate
973-386-5012

Cc: Stephen Sickel
Pyong Deletis